Office of Administration

Commissioner's Office

"Request for Preauthorization for Other Services"

Program: **Alternatives to Abortion**
Contractor: Nurses for Newborns
Subcontractor: N/A

Please enter below the information for each item/service to be purchased. List the date of purchase, item to be purchased, cost for the item, and the justification. Items must be approved **before** purchased/provided to be reimbursed.

Client Name: [redacted] *Date Enrolled:* 1/31/17

Proposed Purchase Date	Item	Total Cost (include formal estimate from provider of services)	Justification, include other sources of funding that have been attempted
March 2017	Power Steering Repair	415.48	Client's only mode of transportation for education, job search, med appointments. Obtained donations from church for tires, needs further assistance for Power Steering.
AMOUNT TO BE REIMBURSED			

Please return to Alternatives to Abortion Program Manager, State of Missouri – Office of Administration, Commissioner's Office, State Capitol Building, Room, 125, Jefferson City, MO 65101. May be faxed to 573/751-1212 or emailed to emily.kraft@oa.mo.gov by the Contractor only!
Thank you.

Authorized person requesting purchase: Megan Bergeman

Approved for purchase: Emily Kraft Date 3/14/17

Purchase denied: _____ Date _____

Reason for denying purchase: _____

ALTERNATIVES TO ABORTION PROGRAM
Assistance Request

This form is to be completed by an NFN Nurse ONLY and must be completed entirely for timely approval and submission.

DATE: 3 / 3 / 17 CLIENT NAME: [redacted]

The above named client is requesting assistance through NFN's ATA Program for the following:

___ **Rent**
(if new request, a W-9 and Lease MUST accompany this form)

___ **Utility**
(if Ameren, provide account number and account holder's name; if Laclede, provide bill)

X **Transportation**
(if new request, no additional information is needed; if repeat request for gas card ONLY, please provide receipts)

___ **Other**
(Pre-Authorization Request and documentation of the bill/invoice/etc. to be paid MUST accompany this form)

Landlord/Utility/Other NAME: Mike's Car Care Center

BILL TOTAL: $ 415.48 AMOUNT YOU ARE PAYING: $ 0 AMOUNT REQUESTED: $ 415.48

OTHER RESOURCES ATTEMPTED FOR ASSISTANCE (must list at least three):

1. _____ Agency Representative: _____
2. _____ Agency Representative: _____
3. _____ Agency Representative: _____

I understand this is a one-time payment. This assistance is intended to assist you in the delivery of a healthy baby or in keeping your child on target developmentally. I have completed a ***Budget Form*** *and* ***Individualized Pregnancy Continuation Plan*** *(IPCP) with my nurse in order to ensure my ability to pay this bill in the future.*

_____ _____
(client signature) (date)

Julii Conaway, RN 3-3-17
(RN signature) (date)

IPCP Completed/Submitted: _____ (initial) Budget Form Completed: _____ (initial)

Date Received: _____ Date Pledged/Submitted for Payment: _____

Mike's Car Care Center

681 West Lions Club Dr.
Rolla, MO 65401
573-368-5523

Estimate

Date	Estimate #
3/1/2017	[redacted]

Name / Address

[redacted]

Project

Description	Qty	Cost	Total
Power Steering Pump		110.00	110.00T
Power Steering hose		120.00	120.00T
Labor Charge for repairs	2.8	60.00	168.00

Subtotal	$398.00
Sales Tax (7.6%)	$17.48
Total	$415.48